Royal Cornwall Hospitals NHS Trust

POLICY UNDER REVIEW

Please note that this policy is under review. It does, however, remain current Trust policy subject to any recent legislative changes, national policy instruction (NHS or Department of Health), or Trust Board decision. For guidance, please contact the Author/Owner.

Information Category	Detailed Information
Document Title:	Fetal Abnormality Communication Clinical Guideline V3.0
This document replaces (exact title of previous version):	Fetal Abnormality Clinical Guideline V2.0
Date Issued / Approved:	July 2021
Date Valid From:	July 2021
Date Valid To:	January 2024
Author / Owner:	Rob Holmes – O and G Consultant Obs and Gynae Directorate
Contact details:	01872 252727
Brief summary of contents:	This guideline describes the referral and communication process between the Fetal Medicine Unit (FMU), the Neonatal Team and other relevant specialist services, when a fetal concern is identified.
Suggested Keywords:	Fetal, Medicine, abnormality, neonatal, communication, scan, perinatal, morbidity
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Maternity Guidelines Group
Manager confirming approval processes:	Caroline Chappell

Information Category	Detailed Information
Name of Governance Lead confirming consultation and ratification:	Tamara Thirlby
Links to key external standards:	No
Related Documents:	None
Training Need Identified:	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy on Document Production. It should not be altered in any way without the express permission of the author or their Line Manager.

One + all | we care

Royal Cornwall Hospitals NHS Trust

Fetal Abnormality Communication Clinical Guideline

V3.0

July 2021

1. Aim/Purpose of this Guideline

1.1. This guideline describes the referral and communication process between the main Ultrasound Department, the Fetal Medicine Unit (FMU), the Neonatal Team and other relevant specialist services, when a fetal concern is identified.

1.2. This version supersedes any previous versions of this document.

Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the DPA18 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed and documented. We cannot rely on opt out, it must be opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the *Information Use Framework Policy* or contact the Information Governance Team rch-tr.infogov@nhs.net

2. The Guidance

2.1. Referral to FMU

When a sonographer identifies a possible fetal abnormality, he/she should ring FMU on (01872 25) 3092 to make a referral. If the administrator is not available an answerphone message should be left with full details of the woman (name, number and contact details) and the fetal issue of concern. The woman should be informed that FMU will contact her directly within one working day to arrange an appointment with a Fetal Medicine Consultant. The target is that this should be offered within three working days of the referral.

2.2. Communication after FMU assessment

A report will be written in the Viewpoint database and this is accessible on the E3 Maternity database. A printed copy will be placed in the handheld notes and, when relevant, sent to the Lead Neonatologist (see below) and to the GP. Any antenatal, intrapartum or neonatal management required will be described within the report and in the Management Plan of the handheld notes. Quick access to this important information will be aided by referencing the relevant Viewpoint report in the Management Plan within the handheld notes and in E3.

When a serious abnormality is identified, the midwife supporting the FM clinic will notify the community midwife by phone.

2.3. Fetal Medicine, Neonatal and Genetics Multidisciplinary Team Meeting

(MDT), the 'Fetonatal' Meeting

- The MDT takes place three times a month. Attendance includes Fetal Medicine Consultants and Midwives, Consultant Paediatricians with an interest in neonatology, Senior Neonatal Nurses, trust sonographers, Consultant Radiologist and Clinical Genetics Consultant and nurses.
- The meeting enables the FMU team to inform other specialty colleagues of newly identified abnormalities and to update on cases under surveillance. Mode, timing and place of delivery will be discussed and agreed.
- The neonatal team will update on the progress of babies currently on the Neonatal Unit and those with congenital anomalies who remain under paediatric review. A ledger on the Neonatal Unit that records abnormalities newly identified after delivery will be brought to the meeting and the antenatal sonographic history reviewed. If the anomaly is considered to be a potentially missed antenatal diagnosis, the FMU Consultant Lead will inform the Lead Main Ultrasound Department Sonographer of the case.
- The Clinical Genetic team will advise both FMU and Neonatal colleagues of genetic implications of an anomaly under discussion.
- A record of antenatal and neonatal cases discussed at this meeting will be kept on the FMU database. This record will only record new information relevant to on-going care obtained in these discussions. A record of attendance will be kept.

2.4. Referral to Neonatal services

When a fetal abnormality or other case with neonatal implications is identified in FMU:

- A copy of the Viewpoint report is sent to the Lead Consultant Neonatologist. The Lead Neonatologist will reply in writing to the Fetal Medicine Consultant. This letter will be an acknowledgement of receipt of the information and contain a plan, if required, for the early neonatal care. The Neonatal letter is e-mailed to the Neonatal IT Administrator for uploading on to E3. It is the responsibility of the admitting midwife to review E3 for any such documents . A copy also goes to the woman.
- When the woman is next reviewed in FMU, any early neonatal care advised by the Neonatologist will be entered onto the Management Plan page of the handheld notes and E3.

2.5. Referral to Clinical Genetics

When a previous history or clinical condition indicates referral to genetics, a copy of the Viewpoint scan (and cytogenetics or post-mortem reports when relevant) is sent via e-mail with a completed referral front sheet. Prior to sending, the Clinical Genetics Department should be contacted by phone (number is on the referral form) from FMU. A copy of the referral is kept in the referral file in FMU and noted on the Viewpoint system. Any correspondence from the genetics department is filed in the hospital notes. A copy of this correspondence is given to the woman by the Clinical Genetics Department.

Clinical Genetics referral may be agreed after discussion at the Fetonatal Meeting and the same referral process should be used.

2.6. Referral to other professionals and agencies

All newly identified fetal abnormalities will be notified to the Southwest Congenital Abnormality Register (SWCAR). For a number of abnormalities, referral will be made to organisations/clinicians for provision of additional support and information e.g. Cleft Lip and Palate Association (CLAPPA) and Bristol Cleft Team and Royal Cornwall Hospital Physiotherapists for talipes.

2.7. Communication with the woman

Communication with the woman is on going at every appointment and a copy of the Viewpoint report is inserted into her hand held notes after each visit. All Viewpoint reports are available for view within the E3 Maternity Database. (New 2018) Patient written information is given where appropriate and national leaflets are used when available. When any additional information of importance to the woman (diagnosis or management) is obtained in discussion between health professionals, this will be communicated to the woman either by letter, telephone or at a follow up appointment. Women under the care of FMU may contact the department by telephone 01872 252682 with any concerns between appointments.

2.8. Communication and referral to a tertiary centre

2.8.1. **Fetal cardiac abnormalities**: a telemedicine link is set up with the Paediatric Cardiology Department at Bristol Children's Hospital (or referral for scan in Bristol, when preferred by the Cardiologist) for ultrasound diagnosis, further counselling and monitoring and a plan made for place of delivery and neonatal care. The Bristol team will send a full summary of the consultation (by telemedicine or in person in Bristol) back to the Fetal Medicine Department. This is uploaded to the E3 and Maxims databases by Fetal Medicine Administration staff and a copy is sent to the Lead Neonatologist . Plans are also communicated to our local neonatologists in discussion at the weekly Fetonatal meeting.

2.8.2. **Fetal surgical abnormalities:** Cases likely to require neonatal surgery are referred to the FMU at St Michael's Hospital in Bristol. Their staff will arrange for a paediatric surgeon to meet the parents and counsel about possible treatment. A fetal medicine second opinion will also be given at this appointment. A decision is made about frequency and setting of antenatal follow up and place of delivery. This is communicated back to the referring Fetal Medicine Consultant in Cornwall and thereby to the Lead Neonatologist by letter and in discussion at the weekly Fetonatal meeting. A copy of the report will be filed in the woman's hand held notes by the tertiary centre. Despite plans to deliver at a tertiary centre, a woman may present locally in preterm labour so instructions for early neonatal care will be uploaded to the E3 and Maxims databases by Fetal Medicine Administration staff.

2.8.3. **Fetofetal transfusion syndrome:** All cases meeting Quintero Stage 1

disease or greater will be discussed by telephone with FMU colleagues in the tertiary centre in Bristol. A plan of ongoing care will be agreed and clear instructions obtained for referral for invasive treatment. This discussion is documented in the Viewpoint report.

2.8.4. **Brain abnormalities:** When diagnostic accuracy or management would be aided by MRI, this will be requested by emailed referral to the Department of Neuroradiology at North Bristol NHS Trust. MRI reports will be uploaded to Maxims by Fetal Medicine Administrative staff.

2.8.5. **Other Fetal Abnormality cases:** The two local FM Consultants will discuss any challenging cases with each other and provide second opinions. Where there is any doubt or potential controversy about the management, a tertiary FM consultant discussion by telephone will be sought and documented on Viewpoint. Where there is major diagnostic uncertainty, a tertiary centre second opinion will be offered to the parents.

2.9. Maternal Medicine Cases

2.9.1. Cases that do not require FMU input but have anticipated implications for the neonate are communicated to the Lead Consultant Neonatologist by letter from the Consultant Obstetrician responsible for the woman. The Neonatalogist will make a Neonatal plan, summarised in a letter uploaded to the E3 database

2.9.2. The Specialist Midwife responsible for maternal drug abuse will communicate by letter to the Lead Consultant Neonatologist details of all cases that have neonatal implications. The Neonatalogist will make a Neonatal plan, summarised in a letter uploaded to the E3 database

2.10. Termination of Pregnancy for Fetal Abnormality

When there is any uncertainty as to whether an abnormality meets ground E of the Abortion act ('substantial risk…….seriously handicapped'), the FM consultant will discuss with senior multidisciplinary colleagues (variably FMU doctors and midwives, Neonatal doctors and nurses, radiologists and/or geneticists) before a termination is offered to the parents. This discussion will be fully documented.

2.11. Woman presenting acutely with a known fetal abnormality

2.11.1. When a woman presents in threatened or established preterm labour or requires urgent delivery for maternal or fetal compromise, it is the responsibility of the Obstetric Middle Grade Doctor in liaison with the Consultant Obstetrician responsible for the patient (or for Delivery Suite depending on the circumstances and time of day) to discuss the case as a matter of priority with the Senior Neonatal Nurse and Paediatric Middle Grade Doctor.

2.11.2. When there are problems with cot availability or delivery was planned to take place in the tertiary centre, the on call Obstetric and Neonatal

Consultants will discuss the appropriateness of in utero transfer (see RCHT Inutero Transfer Out of Royal Cornwall Hospital Trust (RCHT) - Clinical Guideline). Senior involvement from both the obstetric and neonatal teams is appropriate when an emergency delivery is being considered at extremes of prematurity.

3. Monitoring compliance and effectiveness

Element to be monitored	• Record keeping by Obstetricians, Neonatologists, Midwives, Nurses, and other Allied Health Professionals
Lead	• Antenatal and Newborn Screening Coordinator
Tool	• Viewpoint report filed in the medical notes • Was the view point report copied to the Lead Consultant Neonatologist • Was a referral required to any other specialist/tertiary service • Evidence of the required referral in the medical records • Evidence that the case was discussed at the Fetonatal Meeting
Frequency	• Once during the period of this guideline or earlier if concerns are identified
Reporting arrangements	• Maternity Patient Safety Forum or Clinical Audit Forum
Acting on recommendations and Lead(s)	• Deficiencies identified will be discussed at the Maternity Patient Safety Meeting / Clinical Audit Forum • An action plan will be developed • An action plan lead will be identified and a time frame agreed for the action • The action plan will be monitored by the Maternity Patient Safety Midwife
Change in practice and lessons to be shared	• A lead member of the forum will be identified to take each change forward where appropriate • Patient Safety Newsletter

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the 'Equality, Inclusion & Human Rights Policy' or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Document Title	Fetal Abnormality Communication Clinical Guideline V3.0			
This document replaces (exact title of previous version):	Fetal Abnormality Clinical Guideline V2.0			
Date Issued/Approved:	July 2021			
Date Valid From:	July 2021			
Date Valid To:	July 2024			
Directorate / Department responsible (author/owner):	Rob Holmes, Consultant Obstetrician Obstetrics and Gynaecology Directorate			
Contact details:	01872 252727			
Brief summary of contents	This guideline describes the referral and communication process between the Fetal Medicine Unit (FMU), the Neonatal Team and other relevant specialist services, when a fetal concern is identified.			
Suggested Keywords:	Fetal, Medicine, abnormality, neonatal, communication, scan, perinatal, morbidity			
Target Audience	RCHT	CFT	KCCG	
	✓			
Executive Director responsible for Policy:	Medical Director			
Approval route for consultation and ratification:	Maternity Guidelines Group Obstetrics and Gynaecology Directorate			
General Manager confirming approval processes	Mary Baulch			
Name of Governance Lead confirming approval by specialty and care group management meetings	Caroline Amukusana			
Links to key external standards	CNST 5.1			
Related Documents:	None			
Training Need Identified?	No			
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet & Intranet	✓	Intranet Only	
Document Library Folder/Sub Folder	Clinical / Midwifery and Obstetrics			

Version Control Table

Date	Version No	Summary of Changes	Changes Made by *(Name and Job Title)*
September 2009	V1.0	Initial Version	Mr Rob Holmes Consultant Obstetrician
April 2012	V1.1	Updated to include Compliance Monitoring	Mr Rob Holmes Consultant Obstetrician
August 2012	V1.2	Changes made to Compliance Monitoring only	Jan Clarkson Maternity Risk Manager
18th September 2015	V1.3	Minor changes: Written information given to women & contact numbers NEW Section 2.4 Referral to other agencies Neonatal cases to be included in reviews	Rob Holmes Consultant Obstetrician
13th July 2018	V2.0	Full review. Changes made to sections 2.1, 2.2, 2.3, 2.4, 2.7, 2.8.3, 2.8.4, 2.8.5 and 2.10	Rob Holmes Consultant Obstetrician
July 2021	V3.0	Full review Updated guidance on electronic maternity records	Rob Holmes Consultant Obstetrician

All or part of this document can be released under the Freedom of Information Act 2000

This document is to be retained for 10 years from the date of expiry.
This document is only valid on the day of printing

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust Policy for the Development and Management of Knowledge, Procedural and Web Documents (The Policy on Policies). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Initial Equality Impact Assessment

Section 1: Equality Impact Assessment Form					
Name of Name of the strategy / policy /proposal / service function to be assessed Fetal Abnormality Communication Clinical Guideline V3.0					
Directorate and service area: Obs & Gynae Directorate			**Is this a new or existing Policy?** Existing		
Name of individual completing assessment: Rob Holmes, Consultant Obstetrician			**Telephone:** 01872 252727		
1. Policy Aim Who is the strategy / policy / proposal / service function aimed at?	This guideline describes the referral and communication process between the Fetal Medicine Unit (FMU), the Neonatal Team and other relevant specialist services, when a fetal concern is identified.				
2. Policy Objectives	To ensure a seamless referral process and effective communication between Multidisciplinary Teams when a fetal abnormality has been detected				
3. Policy – intended Outcomes	Seamless care for both a woman carrying a baby with a fetal abnormality/condition and/or a neonate with a fetal abnormality/condition				
4. How will you measure the outcome?	Compliance Monitoring Tool				
5. Who is intended to benefit from the policy?	All pregnant women and neonates				
6a Who did you consult with	Workforce	Patients	Local groups	External organisations	Other
	X				
b). Please identify the groups who have been consulted about this procedure.	**Please record specific names of groups** Maternity Guidelines Group Obstetrics and Gynaecology Directorate				
What was the outcome of the consultation?	Guideline agreed				

7. The Impact

Please complete the following table. **If you are unsure/don't know if there is a negative impact you need to repeat the consultation step**.

Are there concerns that the policy **could** have differential impact on:

Equality Strands:	Yes	No	Unsure	Rationale for Assessment / Existing Evidence
Age		**X**		All pregnant women and their babies
Sex (male, female, trans-gender / gender reassignment)		**X**		All pregnant women and their babies
Race / Ethnic communities /groups		**X**		All pregnant women and their babies
Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.		**X**		All pregnant women and their babies
Religion / other beliefs		**X**		All pregnant women and their babies
Marriage and Civil partnership		**X**		All pregnant women and their babies
Pregnancy and maternity		**X**		This guideline has a beneficial impact upon all pregnant women and their babies
Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian		**X**		All pregnant women and their babies

If all characteristics are ticked 'no', and this is not a major working or service change, you can end the assessment here as long as you have a robust rationale in place.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment:	**Rob Holmes, Consultant Obstetrician**

If you have ticked 'yes' to any characteristic above OR this is a major working or service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

For guidance please refer to the Equality Impact Assessments Policy (available from the document library) or contact the Human Rights, Equality and Inclusion Lead
india.bundock@nhs.net